Clear Form

FY2013
MIDAP Application
Michigan Department of Community Health
HIV/AIDS Drug Assistance Program

v.13.0 All Previous Versions Obsolete

○ New (NEVER on MIDAP previously)

○ Renewal- Subscriber ID/Member ID (found on SGRX/MIDAP Card, if applicable)

Last Name | First Name | Middle Initial

Address

Please Note: All MIDAP related information will be sent to this address

City | State: Michigan | Zip Code | Phone Number

County | Social Security Number | Birthdate

Gender* : ○ Female ○ Male ○ Transgender

Are You Pregnant?: ○ No ○ Yes

If yes, What is your due date?

Transgender Status: ○ Female to Male ○ Male to Female

PLEASE READ AND COMPLETE ALL SECTIONS -Incomplete applications and/or missing information will not be accepted and/or will delay processing.

Race/Ethnicity* (Check all that apply):

- ☐ Hispanic/Latino
- ☐ Black or African American
- ☐ White
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Pacific Islander/Native Hawaiian
- ☐ Unknown

Please Answer the Following Questions*:

Are you a Resident of the State Of Michigan?	○ Yes	○ No
Are You Homeless?	○ Yes	○ No
Do You Have Private Dental Insurance?	○ Yes	○ No
Do you have or are you eligible for Medicare?	○ Yes	○ No

Household Size And Income - *For each income box checked enter the total received in the box to the right*

Household Size*: (Include yourself, and those supported by you, including spouse, partner and or other dependants living with you.)

Do you receive income from any of the following sources? If, yes check all that apply and indicate the amount in the box to the right.

- ☐ Employment - Monthly Total
- ☐ Self Employment - Monthly Total
- ☐ Unemployment - Monthly Total
- ☐ Social Security Disability Income - Monthly Total
- ☐ Supplemental Security Income - Monthly Total
- ☐ Public Assistance - Monthly Total
- ☐ Pension - Monthly Total
- ☐ Retirement - Monthly Total
- ☐ Other - Monthly Total
- ☐ None - If checked, DHS application must have been filled out and submitted to DHS prior to applying for MIDAP

Medical/Prescription Coverage - Check all that apply and provide additional information as listed

1. Do you have medical insurance through any of the following? (If YES, Check all that apply and provide additional information, if NO, move on to the #2) ○ Yes ○ No

- ☐ Employer Sponsored Insurance - Including COBRA Policies — Name of Carrier | ID Number
- ☐ Medicare - Medicare ID | Part A Start Date | Part B Start Date
- ☐ Individual Policy (paid for by you or other entity) - Name of Carrier | ID Number
- ☐ HIP-Health Insurance Program for Michigan - ID Number | Start Date
- ☐ Veteran's Administration Benefits - VA Location/City Where You Receive Care

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Medical/Prescription Coverage Continued

2. Do you have Prescription coverage/ insurance through any of the following that require you to pay a copay and/or deductible at the pharmacy? ◯ No(move on to next section) ◯ Yes (check all that apply below and provide additional information)

☐ Prescription/Rx Copays - Employer Sponsored Insurance Including COBRA policies - Name of Carrier _____ ID Number _____ RxBin No. _____ RxPCN No. _____ RxGrp No. _____

☐ Medicare Part D (Prescription/RX Only) Name of Part D Plan - _____ ID Number _____ RxBin No. _____ RxPCN No. _____ RxGrp No. _____

☐ Prescription/Rx Copays- Individual Policy (paid for by you or other entity) - Name of Carrier _____ ID Number _____ RxBin No. _____ RxPCN No. _____ RxGrp No. _____

☐ Prescription/Rx Copays HIP-Health Insurance Program for Michigan through PHP - ID Number _____ Start Date _____ RxBin No. _____ RxPCN No. _____ RxGrp No. _____

☐ Veteran's Administration Benefits - VA Location/City Where You Receive Care _____

Please Indicate What Type Of MIDAP Assistance You Are Requesting (Check One Only)*:
For complete instructions, please visit http://www.michigan.gov/dap or contact MIDAP at 1-888-826-6565 to request an instruction booklet. Incomplete applications and/or missing information will not be accepted and/or will delay processing.

◯ Private insurance/COBRA Copay Assistance-
1. Enter your prescription/Rx coverage information above.
2. Provide proof of income for most recent month (4 week/30 days)- see instructions for acceptable proof of income. If -0- income, you must apply for medical assistance through DHS.

◯ Medicare Part D Prescription Drug Plan Copay Assistance-
1. Enter your Medicare information under #1 medical coverage above.
2. Enter your Medicare Part D Prescription Drug Plan (PDP) under #2 above.
3. Provide proof of income for most recent month (4 week/30 days)- see instructions for acceptable proof of income. If -0- income, you must apply for medical assistance through DHS.
4. Provide a copy of your Low Income Subsidy/Extra Help status as determined by the Social Security Administration

◯ Full Drug Assistance-
Date of Last DHS application for Medical Assistance _____
Medicaid ID or DHS Case No.(if available) _____
You must have applied for Medicaid or the Adult Medical Program prior to applying for MIDAP

◯ Veteran's Administration Copay Assistance-
1. Enter your VA information under question #1 and #2 above
2. Provide proof of income for most recent month (4 week/30 days)- see instructions for acceptable proof of income, If -0- income, you must apply for medical assistance through DHS.

Proof Of HIV Status/Lab Update
New Members: Must have physician signature **and/or** laboratory results indicating HIV+ status.
Renewal members: Must fill in section with updated lab values, physician signature and name not required.

Absolute CD4 Number/mm3: _____ Date of Test Result _____

HIV RNA/Viral Load _____ Copies Date of Test Result _____

Physician Signature _____ Physician Name _____

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Consent Form/Authorization for Release of Information

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I authorize MIDAP to receive, disclose, and discuss medical/dental information related to the care and treatment of my HIV infection with any health insurance or government health insurance program, or other individuals as required and necessary. .

I understand that the information I have provided on this application will be shared with other government agencies,health insurance companies and/or the contracted pharmacy benefits manager for the purpose of verifying the accuracy of the information provided and in determining my eligibility for MIDAP and/or other programs that I may be eligible for.

I understand that if I become enrolled in a health insurance program prescription coverage or if I qualify for medical assistance through other federal, state or county medical benefit programs, I must immediately notify the Michigan Department of Community Health, Drug Assistance Program (MIDAP) and Michigan Dental Program (MDP) in addition to my pharmacist, and physician.

I understand and agree to submit periodic information regarding my continued eligibility for MIDAP, including proof of income, proof of residency, health insurance coverage, and general updates on forms provided by the MIDAP. I understand that changes in my situation will be evaluated to determine my continued eligibility for MIDAP. I will be notified in writing if I am to be discontinued from MIDAP.

I understand that I must annually, or as required to fulfill funding requirements, recertify as eligible for MIDAP to receive assistance with my medications. I understand that if I submit an application that is determined to be incomplete in fulfilling the requirements for approval that I will not be eligible for assistance until all the requirements are met.

I understand that if any of the information provided on this application changes that I must notify the MIDAP immediately. In addition, I understand that failure to report changes and/or reporting of inaccurate information will affect MIDAP coverage and program eligibility.

I understand that by utilizing MIDAP for medication assistance and by filling prescriptions using my SGRX/MIDAP card that I am agreeing to abide by all MIDAP policies and procedures.

I understand that MIDAP is not insurance and is not valid outside of the state of Michigan.

The information that I have provided on this application is complete and true to the best of my knowledge. I certify that I meet the eligibility requirements as specified in the instructions and have followed the necessary steps that are required for me to be eligible for the Michigan Drug Assistance Program.

This application, when completed, contains patient information that must be protected in accordance with the Health Insurance Portability and Accountability Act.

Case Manager: _____ Phone Number _____

Signature of Applicant _____ Date Signed _____

PLEASE MAIL OR FAX APPLICATION AND ANY SUPPORTING DOCUMENTATION TO:
MIDAP
109 Michigan Avenue, 9th Floor
Lansing, Michigan 48913
Phone: (888) 826-6565
Fax: (517)335-7723

MIDAP OFFICE USE ONLY

Total Monthly Income $_____

F(3000) _____PI(4000) _____MD(6000) _____ HIP(7000)_____ER(5000) _____ HIVC(2000) _____VA (1000) _____

Denied:_____ Reason:_____

Reviewed By: _____ Date: _____ Member ID: __ __ - __ __ __ - __ __ __